

Actuarial Issues of Health Insurance Reform

An Honors Thesis (Honors 499)

by

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## Abstract

When it comes to insurance, actuaries are the experts. It is the role of an insurance actuary to price insurance products, by calculating premiums and reserves using their best estimates for future expenses and claim payments. Reforming the US health insurance system will require much expertise from actuaries. The purpose of this paper is to analyze health insurance reform from an actuarial perspective. The paper gives a history of health insurance in the US, states issues that actuaries consider most important, and evaluates current legislation based on how well it adheres to actuarial issues.

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## Introduction

After being in the emergency room for eight hours, I was given an IV, some pain medicine, food, and had many blood tests. During the four hours I was treated for a viral infection not once was I told the price of any of the care I was given nor asked if I had health insurance. At one point I did give a woman my health insurance card, health insurance I receive from my father's employer. No one even mentioned how or when I would be receiving the bill or any estimate of the overall cost.

Today in Washington and across the nation there is much talk about reforming health insurance. Some want a single payer system, like many of our European allies and northern neighbor. Despite how individuals think the health insurance industry should be changed, everyone agrees that there is a huge lack of transparency. Health insurance is a product just like auto and home insurance, yet it is treated instead as a public good. People receive care first then are billed without receiving an estimate of cost during treatment.

The purpose of this paper is to dissect health insurance from an actuarial perspective. The top issues actuaries consider most important in reforming health insurance are identified. The paper is broken down into 3 parts: History of US Health Insurance, Actuarial Issues, and Current Legislation.

Section I examines the health insurance system that we Americans know today, by giving a brief history of its evolution. Section II states actuarial issues that should be addressed within any proposal to reform the health insurance sector. Section III analyzes the most recent bills in Congress and uses Section II to evaluate the legislation.

### I. History of US Health Insurance

Americans today and over the past 80 years have experienced the health care system that the country knows today. There are many components to the American health insurance system despite its fairly recent creation. This section is broken down to give background information on the current system and how it came to be that way: History and Expansion of US Health Insurance and Health Insurance Providers and Uninsureds.



### A. History and Expansion of Health Insurance

The first accident insurance was sold in the US in the 1850's. Sixty years later the first employer-provided group health insurance policy was created. In the 1920s hospitals began offering services on a pre-paid basis, leading to the first Blue Cross organizations. The first Blue Cross Organization guaranteed to finance hospital stays for people who paid an annual premium to the group. The first present day HMO was introduced in the late 1920s. An HMO (Health Maintenance Organization) is a managed care organization that only covers medical care provided by physicians who have agreed to treat patients following the guidelines set by the HMO. The first HMO's owned their own health care facilities and employed their own physicians. Today's HMOs are more free, having different doctors within various practices within their network.

Medicare and Medicaid were created in 1965 under the Social Security Act. These two plans cover the elderly and low-income citizens, also covering some people with disabilities and qualifying children. After the creation of these two organizations many people who did not have health insurance for various reasons, now had coverage.

### B. Health Insurance Providers and Uninsureds

The US health care system has been broken down into those who have and those who do not have health insurance. Americans who have health insurance have either purchased it through a private health insurance company, either directly or through their employer, or obtained coverage from the government. In order to understand the grave need for health insurance reform, it is imperative to look at our current system: Private Insurance Companies, Medicaid and Medicare, and Uninsureds.

#### 1. Private Insurance Companies

Private Health Insurance Companies offer plans through employers or directly to individuals. In the US 60% of Americans receive health insurance that is provided by their employer, and 9% buy it directly from the insurance company. More and more employers are not offering health insurance to their employees due to rising costs. Premiums and other health care costs are increasing 3 times faster

than wages and inflation. Even at discounted prices through group coverage many households still cannot afford premiums. The cost of insurance is much higher for an individual to obtain directly from an insurance company than through a group at their work. Premiums, deductibles, and co-payments are higher in the individual market, and at the same time the government does not provide tax benefits to compensate for the higher costs.

## 2. Medicaid and Medicare

Medicaid is a health insurance program for eligible low-income people who meet specified means tests. It also covers pregnant women and people with disabilities. Medicaid is funded by the states and the federal government. Federal government contributions depend on the state's poverty level, with the wealthiest states receiving a 50% minimum match. In 2008, 49 million people were covered by Medicaid, costing \$204 billion.

Medicare is a social insurance program provided by the US government to provide health insurance to citizens 65 and over, those who are totally and permanently disabled (payments start after a 2 year waiting period), and end stage renal disease patients. Of these groups, the majority receiving Medicare are 65 years old and over. Medicare operates as a single-payer health care system. It is financed through payroll taxes (1.45% withheld from workers' wages and matched by the employer). In 2008 Medicare covered 45 million Americans, totaling \$386 billion of the federal budget. Workers' deductions soon will not meet the required Medicare payments, because more people are retiring from the baby-boomers generation and advancements in technology are causing life expectancy to increase. If the US population keeps growing and aging at the same rates, with no change to the percentage withheld from employee's wages, then it is predicted that Medicare will not be able to support itself for much longer.

## 3. Uninsureds

Some Americans do not qualify for government health care, their employer does not provide health insurance, they are termed "uninsurable" by insurance companies, or they cannot afford, do not qualify for, or just choose to not purchase



individual health insurance. Almost 46 million Americans in 2007 were uninsured for some part of the year. When an individual is uninsured and seeks medical treatment, they are often billed at much higher rates than those who are insured. An increase in unemployment significantly affects the number of uninsured. The Kaiser Family Foundation is a non-profit that focuses on the major health care issues in the US. According to a report by the Kaiser Family Foundation "A 1% increase in the unemployment rate increase Medicaid and SCHIP (State Children's Health Insurance Program) enrollment by 1million, and increases the number of uninsured by 1.1 million".

## II. Actuarial Issues

The following concepts should be taken into consideration when evaluating a health insurance proposal. In order for a health insurance proposal to be successful it must properly address each of these concepts. The following six actuarial issues are discussed below: underwriting, risk pooling, adverse selection, insurability, affordability, and cost containment.

### A. Underwriting

Underwriting is the process by which insurers decide whether to issue insurance to a person and the terms and prices. An underwriter is an employee of an insurance company whose job is to underwrite applicants for health insurance. "They are responsible for assessing the loss potential of each proposed insured, using information gathered for that purpose" (Black, 651). A goal of underwriting is equity. Insurance companies create equity among its insureds by charging different insurance rates, premiums, and deductibles based on factors such as age and health status.

There are two components of underwriting: selection and classification. Selection is the process where underwriters determine an applicant's expected risk and whether the insurance company is willing to take on that predicted risk. Classification is then used to assign the applicant to a group of people already insured that have the same expected future risks. "The purpose of underwriting is

to ensure that those applying for insurance are assessed and appropriately classified" (Black, 651).

It is very important that an insurance company underwrites its applicants so that it can properly forecast cost of future claims. By knowing as much information as possible about an applicant, underwriters can calculate each applicant's potential risk more accurately. Underwriting standards are enforced not to punish unhealthy individuals but to help an insurance company successfully operate and minimize costs.

Many unhealthy people who need insurance to help cover their extremely high medical bills cannot obtain coverage due to their health status or pre-existing conditions. Many proposals for health care reform state that underwriting standards should be much more lax to nonexistent. Limiting or prohibiting the use of health status and age as rating factors can raise the premiums for healthy individuals relative from what they would pay if age and health status are used as rating factors. Young healthy people are already difficult to attract to the health insurance market because the majority do not foresee health issues. By making the premiums higher due to little to no underwriting, even more people termed healthy will choose to forgo coverage.

Relaxing underwriting standards without seeing any change among the populations' health can only hurt insurance companies, driving costs and premiums even higher. When obese and unhealthy people start to make personal lifestyle adjustments, their health statuses will change. They will become lower risks and the high-risk group will become smaller, but still containing people with pre-existing health conditions that cannot be changed with lifestyle adjustments.

#### B. Risk Pooling

Risk pooling is used by insurance companies to group together individuals who have similar expected claims and risks. "Health insurance risk pools are large groups of individuals whose medical costs are combined in order to calculate premiums" (Risk Pooling, 1). Each person pays premiums that are put into a fund or pool to pay for claims incurred by those in the same risk pool. Each insured must



pay a premium that will sufficiently cover the expected claims for people in their pool, including their own medical bills.

Pooling like risks helps with predictability. The more accurately actuaries can predict future health care claims, the more accurately premiums can be priced to cover an individual's health care costs. The better insurance companies can predict the amount of money they must pay out in claims the more confident the company can be in operating a successful, profitable, and long term self-sufficient business.

Risk pools can be comprised of members with a very similar probability of a loss or can be more diverse, consisting of members of various risk levels. If the pools are finely separated, making them as homogeneous as possible, then those who are highly likely to get sick will pay extremely high premiums. With such high costs it would not be economically feasible for unhealthy people to maintain coverage. Oppositely, if risk pools were more diverse, then healthy people would be subsidizing those who are likely to receive major treatment by paying higher premiums. High-risk people would be paying less because the pool contains healthy people who bring down the costs of premiums.

### C. Adverse Selection

Adverse selection is a byproduct of a voluntary insurance market. Adverse selection is when an applicant has information about them self that the underwriter does not know, and would most likely be a factor on whether the applicant would be approved for insurance or what the insurance rates would be. People choose whether or not to purchase insurance based on what they expect their health needs to be in the future while factoring in the cost of premiums. The first people to apply for health insurance are those who are unhealthy and seek insurance to cover their anticipated expensive health care needs. Those who do not foresee future health issues will think the coverage does not offset the high premiums and will forgo health insurance.

The premium spiral is why adverse selection is one of the top issues insurance companies face. People choose to buy insurance based on cost and expected health needs. Sick people are more likely to buy health insurance and are



the first to purchase health insurance. Premiums increase because many of the insureds are unhealthy and premiums must rise in order to cover the higher risks. Since premiums are now higher healthy people are discouraged from purchasing health insurance because it is even more expensive and they see little benefit since they do not predict to be ill. Now even less healthy people choose to have insurance, so premiums must increase even more. Once this has started it is difficult for insurance companies to bring premiums back down, to a price low enough to attract healthy individuals.

Attracting healthier individuals will ultimately help keep premiums more affordable and stable. Insurance companies must convince the healthy population to obtain and maintain coverage. An individual mandate requires all individuals to have coverage. This will drastically reduce adverse selection. Low risk individuals who might choose to forgo coverage are required to obtain health insurance under an individual mandate. This group will make an insurance pool more diversified and financially offset the high medical costs of the unhealthy insureds. For the individual mandate to be effective the associated financial penalty must be meaningful compared to expected premiums. Otherwise people might choose to pay the lower penalties instead of getting coverage. If the penalty and premiums are close then more low risk people will choose to obtain coverage to at least obtain something for their money, rather than just pay a fine.

#### D. Insurability

An applicant is insurable when they meet standards regarding health status, financial condition, and other personal characteristics set by an insurance company. Some Americans are labeled uninsurable due to factors including preexisting conditions, low-income level, or health status. People above 65 and Americans with lower incomes are eligible for the government provided health care options Medicare and Medicaid. Government programs cover only a portion of Americans.

The large number of uninsureds, especially those with pre-existing conditions, is one of the reasons health insurance reform is seen as a top priority. Pre-existing conditions are defined as “medical conditions which exists on the Effective Date of the policy and within a specified number of years past either:



caused you to receive medical advice or treatment; or caused symptoms for which an ordinarily prudent person would seek medical advice or treatment” (Black, 169). About 5 million Americans who are uninsured have been labeled “uninsurable” due to pre-existing conditions.

One of the reasons insurability and underwriting are such issues in our current system is because of availability. Health insurance is just not available to enough people in this country, thus leaving such a large proportion uninsured. Insurance is not available to people whose employers do not provide health insurance yet they make too much money for government help, and they do not have incomes high enough to be able to afford individual insurance directly from a private insurance company. Insurance is also not available to those who are considered too unhealthy by insurance companies and those with pre-existing conditions. Health insurance reform can make health insurance available to all, but it does not mean that all citizens will actually have health insurance.

#### E. Affordability

According to the United States Census Bureau in 2007, there were 27 million people who lacked health insurance and worked at least part time. Most of these people did not have health insurance because it was too expensive. Over half of those uninsured in the US need financial aid to make the premiums affordable, given their current earnings. Only one in five of uninsureds can actually afford the premiums.

The largest age group to not have health insurance is young adults. Many are removed from their parents’ insurance after completing school. For many of their first jobs, their employer does not provide health insurance and the salary they earn is not sufficient to cover health insurance premiums. Out of all employers in 2007, from small family owned stores up to large corporations, roughly 60% provided health insurance to their employees. Government health insurance is typically not an option for this age group, especially since even the poorest adults do not qualify for Medicaid if they do not have children.

Regardless if an individual has insurance, due to the *Emergency Medical Treatment and Active Labor Act* hospital emergency units must treat all patients.



Unfortunately, the medical costs charged by hospitals to those who lack health insurance are much higher than the costs for insured patients for the same procedures and care. Many uninsureds cannot afford health insurance premiums in the first place, and after incurring extremely high emergency care bills, they have no choice but to file for bankruptcy. More than half of all emergency room care goes uncompensated, leading to a huge cost problem. Costs are inflated for those who can afford insurance to cover the uncompensated treatments provided to those who cannot.

#### F. Cost Containment

Extremely inflated health care costs are the number one reason the health insurance system is under such scrutiny. The following three groups are all responsible for health care costs exponentially growing: Individuals, Health Care Providers, and Insurance Companies. By containing costs individuals, insurers, and health care providers can help the health insurance market become more stable.

##### 1. Individuals

A reason the health care market is in such trouble is because so many Americans are unhealthy due to sedentary lifestyles. The incentives problem deals with making people take responsibility for their own health and weight. So many people nowadays are uninsurable because they are unhealthy and are much too risky for an insurance company.

By making information about the consequences of unhealthy behaviors more available, in a manner that is significant enough to affect individual behavior, people may start to realize the threats of unhealthy choices and start to make changes. The government and private insurers could team up to create an effective and widespread campaign promoting being slim and healthy life styles. Financial incentives could be created to encourage healthier choices and to discourage unhealthy activities; increasing taxes on tobacco, alcohol, or even junk food will discourage some from purchasing these items.

Uninsured Americans are less likely to receive regular checkups and use preventative medicine. By choosing to not have regular doctor visits, illness is usually diagnosed in later stages, when treatment is much more expensive. Also,



since many uninsureds do not have regular doctors, they are twice as likely to go to the emergency room for less-urgent care needs. Since hospitals must treat all patients regardless of their ability to pay, much hospital care goes uncompensated. The unpaid bills are absorbed by taxpayers through higher taxes, to those privately insured with higher premiums (since the insurance company is now being charged more for procedures), and charities.

#### 1. Health Care Providers

Hospitals are for profit businesses that are largely lacking market forces. Hospitals lack market forces because employees of hospitals are typically compensated by a portion of the services provided. The more expensive services, but maybe not very effective, provide more income for hospitals than effective but less expensive procedures (Laham, 41). If hospitals were compensated on effectiveness of services provided and not cost of procedures administered, then there would be significantly less waste in our health care system. Expensive tests and new technologies that provides little health benefits should be cut until they prove their significance.

In any market consumers demand the highest quality goods and services for their money, but this is not seen with hospitals. The insured is billed later for their appropriate percentage of the total cost, without being aware of the costs while treatment was provided. If hospitals and other health care institutions made their costs more transparent, then consumers would have more say in whether a service should be administered, taking into consideration possible health benefits relative to costs.

Germany has universal health coverage, providing health insurance to all of its citizens. Despite what many think, Germany's universal health care system costs less per person than the US's private health insurance market. One of the many reasons Germany's system is so effective and cost efficient is because of transparency. "The simplicity and consistency, both in price and benefits, among the plans offered by the sickness funds increase transparency. Germans know the costs and coverage provided by their health insurance" (Fleischacker).



## 1. Insurance Companies

Insurance companies have extremely high administrative overhead costs. Canada has a single-payer health care system and still has significantly less administrative costs than the US. According to the Kaiser family Foundation "It is estimated that at least 7% of health care expenditures are for administrative costs (e.g., marketing, billing) and this portion is much lower in the Medicare program (<2%), which is operated by the federal government. Some argue that the mixed public-private system creates overhead costs and large profits that are fueling health care spending".

A solution to reduce costs is for insurers to increase deductibles. With a higher deductible people will start to pay for more of their health care services, especially those that are not considered an insurable risk. People should be held more financially responsible to cover costs such as annual checkups and prescription refills.

Besides adjusting deductibles, companies can reduce costs by implementing VBID. Value Based Insurance Design (VBID) is founded on the concept that quality healthcare can be obtained in a cost effective manner by encouraging the use of high-value services and discouraging the use of low value services ("Value Based Insurance Design"). Patients' copayments are based on the relative value and not cost of the procedure or treatment. A more efficient resource allocation can be achieved when the amount of patient cost sharing is a function of the value of the specific health care services provided.

Patients' out of pocket costs are determined by the costs and benefit of care; there is low to no copayment for services with high clinically proven positive values and much higher copayments for services with little to no proven clinical value. Insulin for diabetics or medications for those with high blood pressure would have little to no copayment, while new drug trials and expensive tests with new technology, yet no proven health benefits, will be much more costly to the patient.

"Insurance doesn't create money. It redistributes money, and that's all it can ever do. But as long as people see insurance as a pot of gold to be used, they have no incentive whatsoever to seek efficient treatment rather than intensive treatment.



Until people have to invest their own money into their own treatment, the idea of containing costs is a pretty tough one to swallow" (Barry). The entire health insurance system needs to be reformed with respect to what is and is not an insurable service or good. "Policy makers and the public should be taught that medical insurance should be like other insurance, a financial service that is frequently bought, rarely used, but critical to the physical and financial well-being of the insured's" (Mange). Check-ups and annual teeth cleanings are not unforeseen nor catastrophic events and therefore should not be covered by health insurance. People who need new windows on their home or a new paint job on their car do not expect their respective insurance policies to pay for these services, so why do people demand so much more from their health insurers?

### III. Current Legislation

As of 2009, two health care reform bills have been in Congress. *The Patient Protection and Affordable Care Act* passed through the Senate and *Affordable Health Care for America Act* passed through the House. The two bills are evaluated on how well they address the six actuarial issues from Part II.

#### A. *Patient Protection and Affordable Care Act*

The *Patient Protection and Affordable Care Act* is a Senate bill and covers many of the actuarial issues from Part II. The Act does not create a purely public health insurance option for Americans, but aims to reform private health insurance companies through various regulations.

##### 1. Underwriting

The Act prohibits insurance companies to base coverage off of an applicant's health status, gender, or pre-existing conditions. Since the plan does not offer a public plan that all Americans can join, the new underwriting standards will be a big problem for private insurance companies. Underwriters can only discriminate an applicant based on their age, geographical region, and family size. The bill does require all citizens to buy coverage. Hopefully the individual mandate will bring young healthy people to the market, and help offset the amount of unhealthy individuals and those with pre-existing conditions.

The bill aims to expand Medicare and Medicaid to more individuals by adjusting qualification standards to encompass more people. The bill plans to pay for these changes by increasing payroll taxes on high income earners, creating fines for employers who do not provide health insurance for their employees, and taxing indoor tanning salons.

## 2. Risk Pooling

It is unclear how people will be grouped into different risk pools. Since underwriting is not based on health status then one can conclude that all are paying similar premiums. This bill does not specifically state the cost of premiums for individuals.

## 3. Adverse Selection

This Act requires all individuals to obtain coverage. There are certain exceptions including a hardship waiver and religious objections. Those citizens who still do not purchase health insurance are required to pay a reasonable penalty. This mandate will decrease adverse selection since the goal of making everyone obtain health insurance is to make the young and healthy people obtain coverage. Even if someone chooses to pay the fine, that money can go to help offset the high costs for those who do have coverage.

## 4. Insurability

Underwriting standards are significantly decreased under the bill, making all citizens insurable. Also, people cannot be denied for pre-existing conditions so they too are insurable under this plan. Since all are considered insurable, insurance is now available to all citizens either through their employer or government. With all considered insurable the only people who do not have insurance under this plan will be those who choose not to coverage. There will always be people who qualify for government aid that will not participate. Also there will people who would rather pay a fee than obtain coverage for reasons such as not wanting to comply with the government.

## 5. Affordability

The bill emphasizes making health insurance affordable for all citizens. The bill imposes caps for out-of-pocket expenses. There are also limits on deductibles



and copays. These limits pertain to all private and public health insurance providers. People with lower incomes will receive tax credits to help them afford health insurance premiums. Individuals will be able to go online and easily find out if they are eligible for tax credits.

#### 6. Cost Containment

The bill will try to reduce costs by implementing VBID. Co-pays and deductibles are eliminated for certain preventive care. Medicare will be reformed to compensate health care providers based on outcome and quality of care instead of quantity. Programs to educate communities on preventive medicine and weight management will be established to improve public health.

Another way the bill will reduce health insurance cost is by increasing transparency. Individuals and small employers can go online and easily compare prices of various health insurance providers. Also, if an insurance company decides to increase premiums, it must first publicly notify their insureds and provide justification for the increase. By forcing companies to be more transparent about premium changes, insurance companies will probably be less likely to raise premiums fearing the backlash after notifying its customers.

To help reduce the extremely high overhead costs of private insurance companies, the bill requires insurers to report the percentage of premiums that is spent on costs other than health care. Of those Americans whose health insurer spends over 15% of their premiums on things other than health care, the government mandates that those companies must give their customers a rebate.

Implementing VBID, setting up programs to educate the population on the importance of living a healthy life, and changing Medicare and Medicaid to encompass more citizens are all good ideas in this act, especially since the writers address how they will pay for these changes. One of the bill's main flaws deals with availability. If insurance companies cannot discriminate due to health status and pre-existing conditions then many of them will cease to exist or find ways to get around the lack of underwriting standards.

### *B. Affordable Health Care for America Act*

The *Affordable Health Care for America Act* addresses many of the actuarial issues stated in Part II. The bill was signed by President Obama on March 23, 2010, after it passed through Congress. It originates from the House. The act allows states to set up their own health insurance exchange, competing with private health insurers. The government health insurance programs will be funded by taxes and employer contributions. Employers must either provide health insurance to their employees or contribute to the government plan.

#### 1. Underwriting

The government plans will only set premiums based in an applicant's age, family size, and geography. The bill not only requires the government programs to have guaranteed acceptance of applicants, but private health insurers also can only reject an applicant based on:

- Age
- Family Size
- Geography

There will be no discrimination against anyone based on pre-existing conditions or their health status. For example, if an insurance company can decide to not cover residents of Kentucky, people with four or more children, or anyone over age 70. Therefore a single female, age 45 with type II diabetes in Iowa cannot be rejected if she applies for insurance from the given company. Therefore the new system will have lower administrative costs then that currently of private health insurers. If the new underwriting standards cause private health insurance companies to quit operating, at least citizens can go to the government programs to get coverage.

#### 2. Risk Pooling

The bill will have the government establish a high-risk pool program until the Health Insurance Exchanges are established. This pool will be composed of people who are unhealthy and at a high risk of incurring large medical bills. Members in this high-risk pool will pay higher premiums than other pools. From an



actuarial stand point the creation of this high-risk pool will be too expensive to successfully operate. The pool is not diverse enough to make premiums affordable. Though people considered high-risk will not be denied this coverage, the premiums will have to be set so high that very few of these people will be able to afford the premiums. Once the public exchange is established, those in the high-risk pool will be integrated into the Health Insurance Exchange, a more diverse risk pool based on their geographical region. Now the Exchanges will have the issue that healthy people will be paying premiums higher than what it takes to cover them, and unhealthy participants will pay premiums that are underpriced. This will cause adverse selection. The healthy people will try to switch insurance, leaving the pool a high-risk only pool.

### 3. Adverse Selection

This Act requires all individuals to obtain coverage. There are certain exceptions including a hardship waiver. Those citizens who still do not purchase health insurance will pay a fee proportionate to their adjusted income. This mandate will decrease adverse selection since the goal of making everyone obtain health insurance is to make the young and healthy people obtain coverage. Even if someone chooses to pay the fine, that money can go to help offset the high medical bills of those who do have coverage. The Act will create a position titled the "Commissioner". This person is to regulate and over see the entire health insurance market, making changes where they see fit. The Commissioner is to make reports over detection and solutions for adverse selection.

"Commissioner deems appropriate to ensure that the law does not provide incentives for small and midsize employers to self-insure or create adverse selection in the risk pools of large group insurers and self-insured employers. No later than 18 months after the first day of Y1, the Commissioner shall submit to Congress and the applicable agencies an updated report on such study, including updates on such recommendations." (H.R. 3962. 29)

The individual mandate will bring new people to the health insurance market, the majority being healthy. Since people would rather get something for their money than nothing, it is expected that many will obtain coverage than pay the fine. As long as the government makes health insurance available and affordable to all

Americans, an individual mandate is a good way to fight adverse selection and ensure that all Americans are insured.

#### 4. Insurability

Underwriting standards are significantly decreased under the bill, making all citizens insurable. Also, people cannot be denied coverage for pre-existing conditions so they too are insurable under this plan.

“A qualified health benefits plan may not impose any preexisting condition exclusion or otherwise impose any limit or condition on the coverage under the plan with respect to an individual or dependent based on any of the following: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or source of injury (including conditions arising out of acts of domestic violence) or any similar factors.” (H.R. 3962. 29)

Since all are considered insurable, health insurance is now available to all citizens either through their employer or the government created Health Insurance Exchanges. With all considered insurable the only people who do not have insurance under this plan will be those who choose not to have coverage. There will always be people who qualify for government aid that will not participate. Also there will be people who would rather pay a fee than obtain coverage for reasons such as not wanting to comply with the government. This act makes all Americans insurable by regulating underwriting standards. But not only do all Americans need to be considered insurable to have health insurance, coverage must also be affordable.

#### 5. Affordability

“It is the responsibility of the federal government to ensure that essential health coverage is affordable and available to all Americans by establishing consumer protections and insurance reforms” (“Affordable Health Care for America Act: Detailed Summary”). For lower income families, up to 400% of the federal poverty level, there will be tax credits offered to help them be able to afford premiums. The bill will also create limits for out-of-pocket expenses, with a maximum of \$5,000 for individuals and \$10,000 for families. The government Exchanges will set premiums according to geographical region. The premiums will



be set so that they cover administrative costs and can fully finance health care costs. As long as administrative costs are reasonable then premiums should be affordable for the majority of Americans. The tax credits will also help the young work force afford their own health insurance since many lack coverage after they are removed from their parent's insurance. It will probably take some adjusting to find the exact prices to make insurance affordable, but once these premiums are adequately set there will be little to no reason for most Americans to not have health insurance.

#### 6. Cost Containment

The bill also allocates resources to create a national confidential electronic patient health records system. This system will reduce errors and costs. With the ability to see the complete history of a patient in a matter of seconds, doctors can better diagnose patients, and will not waste time and money with past treatments that were not effective.

On an individual level, the act establishes programs that will also lower costs in the long run. The programs will present information on wellness and preventive medicine to communities. One of the main focuses is to teach individuals how to live healthier, aiming to reduce obesity. These programs are established when a community requests a grant from the federal government. Once the grant is received the committee in charge of the program must establish their course within 90 days. These programs can be renewed yearly, up to five years as long as "the grant or contract recipient demonstrates to the Secretary's satisfaction that the recipients have made appropriate, measurable progress in preventing overweight and obesity" (H.R. 3962. 29). If US obesity levels are significantly reduced then fewer resources will be allocated in the treatment of type II diabetes and heart disease, illnesses that are easily preventable.

The bill thoroughly explains how it will finance its public Exchanges. Medical costs for the public Exchanges are negotiated with health care providers in their respective geographical region, and then are set at these negotiated prices. The bill states that the public Health Insurance Exchanges shall never receive any government bail out in the case of insolvency.

Once the Health Insurance Exchanges are established there will not be a high-risk pool. All types of risks will be pooled together, grouped by their region. Since underwriters can only discriminate on age, sex, and geographical region almost all people will be considered insurable.

For example, an insurance company decides to only cover people with less than 5 children, lives in all US states except Mississippi, and is below 75 years old. An overweight 40-year-old male with a history of heart disease living in Indiana, who only has with 2 children will be put into one of these diverse pools. Everyone in his pool will pay the same rate. Since this is not a high-risk pool, there is likely to people in the pool much healthier than him. He will be paying a lower premium relative to his actual risk, and healthier people in his pool will pay a higher premium relative to their actual risk. It is unclear what exactly these premiums will be, but in order for the health insurance market to be successful these premiums must be set to make them affordable and at the same time equitable.

This bill seems cover many of the actuarial issues efficiently. The implementation of electronic health records will greatly reduce costs. The changes to underwriting will allow all citizens to obtain coverage hopefully at a reasonable cost. With the Commissioner having the ability to make adjustments wherever they see fit, the program should be able to quickly make changes to any sector of the health insurance market that is not efficient and cost conscious.



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